IDAHO DEPARTMENT OF
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
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February 24, 2017

Steve Young, Administrator
Yellowstone Group Home #3 Hoopes
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #3 Hoopes, Provider #13G065

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #3 Hoopes, which was conducted on February 13, 2017.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 9, 2017,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by March 9, 2017. If a request for informal dispute resolution is received after March 9, 2017, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

ASPIRE
HUMAN SERVICES, LLC

March 24, 2017

Jim Troutfetter
Idaho Department of Health and Welfare
Division of Licensing & Certification
Bureau of Facility Standards
P.O. Box 83720
Boise, Idaho 83720

Dear Jim Troutfetter:

This is the Plan of Correction for the survey concluded at Aspire Human Services #3 Hoopes Home, on February 13, 2017. I would like to take the opportunity to thank you, Melanie Shaw, and Monica Nielsen for the helpful information you always share. The survey process is always a learning experience, and we appreciate the wealth of knowledge you offer to our agency. Thank you for a pleasant, helpful, and informative survey experience.

Please find attached the Plan of Correction, which contains specific details on the actions taken by the facility to achieve compliance. If you have any further questions, please feel free to contact Lisa Kunz, QIDP, at 208-523-9839 ext. 1016.

Lisa Kunz

Lisa Kunz
ICF QIDP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G065	A. BUILDING _____ B. WING _____	02/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

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W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 2/6/17 to 2/13/17. The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Monica Nielsen, QIDP Melanie Shaw, QIDP Common abbreviations used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse OCD - Obsessive Compulsive Disorder QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure an individual had access to personal possessions for 1 of 3 individuals (Individual #1) reviewed. This resulted in an individual not having access to his dentures. The findings include: 1. Individual #1's IPP, dated 12/15/16, documented a 52 year old male diagnosed with	W 137	RECEIVED MAR 10 2017 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Kunz | TITLE: QIDP | (X6) DATE: 3/8/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 137	Continued From page 1 moderate intellectual disability and adjustment disorder with mixed anxiety and depressed mood. His record documented he moved into the facility from a facility that was owned by the same company on 1/16/17. Individual #1 was edentulous. A dental note, dated 12/15/16, stated he presented to the dental office with a pair of dentures for cleaning and fitting. During observations on 2/6/17 and 2/7/17 for a cumulative 6 hours 1 minute, Individual #1 was not noted to be wearing his dentures. During an environmental survey on 2/9/17 from 2:15 - 2:48 p.m., Individual #1 was asked where his dentures were located. Individual #1 put his hands in the air and shook his head "no." The Lead Worker was present and was asked about Individual #1's dentures. She proceeded to unlock a digital safe located in a two-drawer file cabinet located in the kitchen. The Lead Worker opened the safe and pulled out a plastic bag containing Individual #1's top denture. The Lead Worker reported the top denture was the only one he had when he was admitted to the facility. Individual #1's record was reviewed and did not contain documentation related to a need to obtain a full set of dentures for Individual #1 or a need to restrict access to his dentures. When asked about the location of his dentures, the LPN, stated during an interview on 2/10/17 from 9:10 - 10:40 a.m., Individual #1 was admitted to his previous facility with two pairs of dentures and they were usually kept in his personal hygiene container. When informed of the findings during the environmental survey, the	W 137		

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W 137	Continued From page 2 LPN stated she was not aware that Individual #1 had only one top denture. The facility failed to ensure Individual #1 had unrestricted access to his full set of dentures.	W 137		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure programs were revised as appropriate for 1 of 3 individuals (Individual #3) whose IPPs and program revisions were reviewed. This resulted in an individual continuing to receive formal training on objectives the individual had successfully completed. The findings include: 1. Individual #3's 7/16/15 IPP stated she was a 23 year old female whose diagnoses included severe intellectual disability, disruptive mood disorder, autism with OCD, and seizure disorder. Individual #3's QIDP Monthly Summaries, dated 9/2016 - 11/2016, were reviewed. The summaries documented Individual #3 met criteria on established objectives for all 3 months without program revisions being made that were reflective of her demonstrated ability. Examples included, but were not limited to, the following: a. Individual #3's showering program involved her	W 255		

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W 255	Continued From page 3 accepting a washcloth from staff with a specific verbal cue in 10 of 12 trials per month for 3 consecutive months. Individual #3 was successful with her showering program for 10 of 10 trials in September, 10 of 12 trials in October, and 10 of 12 trials in November. b. Individual #3's oral care program was to pick up her toothbrush with a light physical prompt in 5 of 12 trials per month for 3 consecutive months. Individual #3 was successful with her oral care program for 7 of 12 trials in September, 6 of 11 trials in October, and 8 of 12 trials in November. c. Individual #3's self-feeding program stated she would take a drink after every 2 bites when eating with a specific verbal prompt in 10 of 12 trails per month for 3 consecutive months. Individual #3 was successful with her self-feeding program for 12 of 12 trials in September, 12 of 12 trials in October, and 11 of 12 trials in November. The QIDP summaries did not include information regarding why the prompt level was not revised when Individual #3 had demonstrated she could complete the tasks as written. When asked, during an interview on 2/10/17 from 9:10 - 10:40 a.m., the QIDP stated Individual #3's objectives had not been revised when she had met criteria. The facility failed to ensure Individual #3's objectives were revised based on her actual performance.	W 255		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE	W 260		

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W 260	Continued From page 4 At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an IPP was revised to accurately reflect and respond to an individual's current needs for 1 of 3 individuals (Individual #3) whose records were reviewed. This failure resulted in an individual's IPP not reflecting her current status or needs. The findings include: 1. Individual #3's IPP, dated 7/6/15, documented she was a 23 year old female whose diagnoses included severe intellectual disability and autism. Individual #3's record was reviewed on 2/8/17 and contained an IPP, dated 7/6/15. No current IPP could be found. When asked, during an interview on 2/10/17 from 9:10 - 10:40 a.m., the QIDP stated Individual #3's IPP had not been updated due to an oversight during a transition between QIDPs. The facility failed to ensure Individual #3's IPP was updated and reflective of her current status and needs.	W 260		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs	W 312		

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W 312	Continued From page 5 are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a behavior modifying drug was used only as a comprehensive part of an individual's IPP for 1 of 2 individuals (Individual #3) whose psychotropic medications were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that accurately identified how the drug may change in relation to progress or regress. The findings include: 1. Individual #3's IPP, dated 7/6/15, documented she was a 23 year old female whose diagnoses included severe intellectual disability and autism. Individual #3's physician's orders, dated 11/20/16, documented she received Seroquel (an antipsychotic drug) 200 mg twice a day. Her Medication Reduction Plan, dated 1/6/16, documented the Seroquel was given for self-injurious behavior and aggression and had separate criteria for each one. The criteria for reduction for aggression stated "Will consider decreasing Seroquel or DC [discontinue] when the objective for aggression has been met. [sic] or [sic] determined that Seroquel isnt [sic] effective." The self-injurious criteria for reduction stated "Will consider decreasing Seroquel or DC [discontinue] when the objective for aggression has been met first. It was not clear why the Seroquel would not be	W 312		

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W 312	Continued From page 6 reduced if she met criteria for the self-injurious behavior prior to meeting criteria for aggression. When asked, during an interview on 2/10/17 from 9:10 - 10:40 a.m., the QIDP stated Individual #3's medication reduction program needed to be revised. The facility failed to ensure Individual #3's medication reduction plan contained comprehensive information.	W 312		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews, it was determined the facility failed to ensure an individual was provided with appropriate adaptive equipment for 1 of 3 individual (Individual #1) who required the use of adaptive equipment. This resulted in an individual not being provided with his dentures. The findings include: 1. Individual #1's IPP, dated 12/15/16, documented a 52 year old male diagnosed with moderate intellectual disability and adjustment disorder with mixed anxiety and depressed mood. His record documented he moved into the facility from a facility that was owned by the same	W 436		

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W 436	Continued From page 7 company on 1/16/17. Individual #1 was edentulous. A dental note, dated 12/15/16, stated he presented to the dental office with a pair of dentures for cleaning and fitting, but did not want to wear his dentures. During observations on 2/6/17 and 2/7/17 for a cumulative 6 hours 1 minute, Individual #1 was not noted to be wearing his dentures. During an environmental survey on 2/9/17 from 2:15 - 2:48 p.m., Individual #1 was asked where his dentures were located. Individual #1 put his hands in the air and shook his head "no." The Lead Worker was present and was asked about Individual #1's dentures. She proceeded to unlock a digital safe located in a two-drawer file cabinet located in the kitchen. The Lead Worker opened the safe and pulled out a plastic bag containing Individual #1's top denture. The Lead Worker reported the top denture was the only one he had when he was admitted to the facility. She stated his bottom denture never came with him from the previous facility. Individual #1's record was reviewed and did not contain documentation related to a need to obtain a full set of dentures for Individual #1 or a training program to teach Individual #1 to wear his dentures. When informed of the findings during the environmental survey, during an interview on 2/10/17 from 9:10 - 10:40 a.m., the LPN stated she was not aware that Individual #1 had only one top denture. The facility failed to ensure Individual #1 was provided with and taught to use his dentures.	W 436		

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the state licensure survey conducted from 2/6/17 - 2/13/17. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Leader Monica Nielsen, QIDP Melanie Shaw, QIDP	M 000		
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W137.	MM134	RECEIVED MAR 10 2017 FACILITY STANDARDS	
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W255 and W260.	MM159		
MM162	16.03.11500 Client Behavior and Facility Practices	MM162		

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MM162	Continued From page 1 The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4)(iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W312.	MM162		
MM169	16.03.11700 Physical Environment The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W436.	MM169		
MM215	16.03.11711.01 Good Repair Each building used by the ICF/ID and its equipment must be in good repair. This Rule is not met as evidenced by: Based on observation and staff interview, it was	MM215		

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MM215	Continued From page 2 determined the facility failed to ensure the building was maintained in good repair for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An observation was conducted at the facility on 2/9/17 from 2:15 - 2:48 p.m. During that time, the following was noted: - In Individual #1's room, the top dresser drawer was broken. The left side of the drawer was 1/2-inch lower than the right side and was difficult to open. A coaxial cable was run loosely from behind the Individual #1's TV, around the adjacent closet door frame with protruding loops and continued along the length of the adjacent wall creating an unsafe environment. The window blinds had a 4-inch section of broken blind. - In Individual #2's room, the dresser's fourth drawer was stuck and difficult to open. The window blind had a broken slat. The wall to the left of the dresser had three screw holes that exposed sheet rock. - In Individual #4's room, the bottom drawer of the end table was broken and would not close. The third drawer was missing the pull handle. The finish was visibly worn on the right side of the end table and legs, exposing bare wood creating an uncleanable surface. The window blind had a broken slat. The floor molding was missing around the entire perimeter of her bedroom. - The master bathroom located off of Individuals #4's and #5's bedroom was missing paint on the door edge and door frame/molding approximately 4-inches above and below the door strike plate	MM215		

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YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

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MM215	Continued From page 3 creating an uncleanable surface. Below the towel dispenser, there were 5 screw holes and 3 screw holes in the wall by the toilet. On the left hand wall behind the garbage can, there was a 2-foot x 4-inch section that was missing paint creating an uncleanable surface. There was a 12-inch dent in the front of the metal garbage can. The vanity had 4 door handles that were loose. Along the right hand side of the shower, the caulk was missing between the shower enclosure and the wall. This created a 5-foot x 1/8-inch gap running from the floor to the top of the enclosure creating an uncleanable surface. The top ledge of the shower enclosure had a build-up of dust and debris that was tacky to the touch. - In the hall bathroom, two of 4 lights bulbs were burned out in the light fixture above the sink. - The laundry room door, leading out the garage, was missing a 2-foot section of paint along the door edge. - In the kitchen, the flooring in front of the pantry had a 14-inch scrape mark following the path of the door opening. The door handle on the pantry door was loose. - In the living room near the front door, the corner of the adjoining walls had a 5-inch section of missing paint, there was a 1 1/2-foot section of paint missing near the fireplace and a 7-inch area of missing/chipped paint on the wall adjacent to the dining room table. - The flooring in front of the dining room patio door was missing a piece of vinyl approximately 4-inches x 6-inches. - The threshold of the patio door was loose and	MM215		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G065	A. BUILDING: _____ B. WING _____	02/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

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MM215	Continued From page 4 unstable causing a tripping hazard. - The patio door facing outside was missing paint along the length of the door under the glass pane to the door threshold. - The 4 sets of blinds in the dining room covering the windows and patio door had several broken and missing slats. - The back yard fence facing the south side of the property had several broken wooden slats. When asked during an interview on 2/10/17 from 9:10 - 10:40 a.m., the Program Director stated the maintenance person had been out on medical leave and a temporary person had just been hired to begin repairs. The facility failed to ensure the facility was maintained in good repair.	MM215		

W137

1. Individual #1 will meet with the denturist to be fitted for a new set of dentures. Additionally, Individual #1 has a formal program, written and implemented by the QIDP, designed to assist with desensitizing him to denture use. The program implementation will be documented by DSP staff, and will be reviewed monthly by the QIDP. The QIDP will include a summary of the program data in the QIDP Monthly Summary, which will be completed monthly by the QIDP.

   The program will be reviewed bi-annually via inter-agency peer review by the QIDP peer review process and also annually, by the Quality Assurance department. These reviews will use the recently revised Internal Review packet, which is more specific and inclusive than its previous incarnation.

   Individual #1 was provided with a labeled, sealable, washable container in which to store his dentures sanitarily within his bedroom, allowing him unrestricted access his dentures. The Program Supervisor is responsible for ensuring the upkeep and replacements, as needed, of containers used to store Individual #1's dentures. The Program Supervisor will delegate the house Lead Worker to check the container weekly for cracks, lack of proper sealing, odors, or other observable signs of wear, and to wash the container using warm water and a mild dishwashing detergent. The container will be replaced quarterly and as needed (if cracks, lack of proper sealing, odors, or other signs are observed that indicate the integrity of the container has been compromised). The Program Supervisor will provide the Lead Worker with a documentation form to document container inspection and status. The Lead Worker will complete the form and submit the form to the Program Supervisor. The Program Supervisor will review the form monthly and address any issues noted. The Program Supervisor will implement the documentation form and task delegation to the Lead Worker by April 1, 2017.

2. All individuals residing in Aspire Human Services' ICF homes have personal property inventories completed at the time of admission. Blank inventory forms are located on the agency SharePoint site and are accessible to all Aspire Human Services management and administrative staff. To ensure ongoing accuracy of inventory records, these inventories will be updated as new and additional items are purchased or otherwise obtained or when items are discarded. Additionally, these inventories will be reviewed and updated by home staff yearly during the month prior to the individual's scheduled IDT meeting.
3. Any individuals who use adaptive equipment will have the equipment listed on both the IPP appendix as well as their personal property inventories. The QIDP is responsible for ensuring all adaptive equipment is listed on the IPP appendix document. Adaptive equipment which belongs to the agency but which is used exclusively by one individual will have the adaptive equipment listed on both the IPP appendix as well as their personal property inventories with a note stating the equipment is the property of the agency but is used exclusively by that particular individual. Photos of items may be included as part of the property inventories in order to provide clear documentation of items.
   Adaptive equipment will be checked quarterly for observable signs of wear, cracks, odors, tearing, or other observable factors which may indicate a need for cleaning, repair, and replacement. The Program Supervisors are responsible for delegating adaptive equipment inspection process to the house Lead Worker. The Program Supervisors will provide the house

Lead Workers with a checklist, developed by the Program Supervisor, indicating all adaptive equipment used by each individual, and specifically how each piece of equipment is to be checked for needed repairs. The Program Supervisor is responsible for including adaptive equipment in the house environmental checklist. The house environmental checklist is completed monthly by the house Lead Worker and reviewed monthly by the Program Supervisor.

4. The inventories will be reviewed yearly by the Program Supervisor, during the month in which the individual's IDT is scheduled, to assess property needs, and will address any property needs or concerns at the individual IDT meetings. The inventories will be stored in the Program Supervisor's office in a binder specifically for that purpose. When the inventories are due for review, the Program Supervisors will copy the inventory and keep the copy until they receive the updated document. When new items are purchased or received or when items are discarded, home staff will notify the house Lead Worker regarding the change, and the Lead Worker will communicate the changes in writing to the Program Supervisor, who will revise the inventory document to reflect the changes.
5. Persons responsible: Program Supervisor, QIDP, Program Director, Lead Worker, Quality Assurance department, LPN.
6. Completion Date: April 1, 2017

W255

1. Individual #3's formal programs were updated by the QIDP and the revised programs implemented.
2. All residents' formal programs have been reviewed by the QIDP and Program Director to ensure no other individuals are affected by the same deficient practice.
3. The QIDP has developed an alert system, using "Microsoft Outlook," to provide regular, ongoing reminders regarding program revisions. Additionally, the QIDP has adopted a color-coded system on the program data tracking form, which indicates when program criterion has been met and when programs have been revised. The color-coded system had previously been being used by some, but not all, QIDP's in the Idaho Falls office and is now universally used in the Idaho Falls office. The Idaho Falls QIDP team also visited the Pocatello branch of the agency and received additional training regarding program tracking from the QIDP team at that branch, and has adopted several tracking systems and checklists as a result of that training.
4. All resident programs will be reviewed bi-annually via inter-agency peer review by the QIDP's peer and also annually, by the Quality Assurance department. These reviews will use the recently revised Internal Review packet, which is more specific and inclusive than its previous incarnation. The Program Director receives copies of the Internal Review packet with all applicable revisions and corrections no later than ten days following the completion of the Internal Review by either the QIDP team or the Quality Assurance department, to ensure any issues identified in the quality assurance process were completely addressed in a timely manner and meet both agency policy requirements as well as state regulations.
5. Persons responsible: QIDP, Program Director, Quality Assurance department
6. Date of completion: April 1, 2017

W260

1. Individual #3's IDT meeting was held on July 21, 2016 at 9:30am at the Aspire Human Services Idaho Falls agency. The meeting was presented and facilitated by the individual who previously held the QIDP position. The current QIDP entered the position on August 18, 2016. Individual #3's IPP document had not been completed at that time and there was a lack of and/or a miscommunication between the exiting QIDP and the entering QIDP regarding outstanding documentation and plans requiring completion. Individual #3's IPP has been updated by the QIDP and will be sent to IDT members for review no later than April 1, 2017.
2. All other individual's IPP files have been reviewed by both the QIDP and Program Director to ensure no other individuals have been affected by the same deficient practice. The Program Director will review completed IPP documents for completion no later than 10 calendar days following an individual's IPP meeting. The QIDP has developed an alert system, using "Microsoft Outlook" to provide ongoing reminders regarding deadline dates to ensure IPP documents are completed in a timely manner per agency policy and state regulations.
3. The QIDP will develop a checklist to be used by persons exiting the QIDP position to document outstanding or otherwise incomplete plans. This checklist will be provided in writing to the Program Director for implementation no later than April 1, 2017.
4. This checklist will be reviewed with the Program Director prior to the exit of the positon. The Program Director will review the checklist with persons incoming to the QIDP position, and will again meet with the incoming QIDP within 10 days of date of hire to review the checklist for completion of any items included within.
5. Persons responsible: QIDP, Program Director
6. Date of completion: April 1, 2017

W312

1. Individual #3's medication reduction plan has been reviewed by the QIDP to ensure it is accurate and comprehensive. It will be peer-reviewed by another QIDP by April 1, 2017, to ensure it is accurate and comprehensive. It will be sent to the prescribing psychiatrist for review and psychiatrist signature by April 5, 2017.
2. All other individual's IPP files have been reviewed by both the QIDP and Program Director to ensure no other individuals have been affected by the same deficient practice.
3. The Idaho Falls QIDP team visited the Pocatello branch of the agency and received additional training regarding medication reduction plan development and implementation from the QIDP team at that branch. As a result of the training, the QIDP team has adopted several new and revised tracking systems and checklists, which include the review and modifications of medication reduction plans.
   The QIDP will update all medication reduction plans within 7 days following any psychotropic medication changes, programmatic changes, or medical events which may influence or be influenced by psychotropic medications. The QIDP will include information regarding medication reduction plans in the QIDP monthly summaries.
4. All resident programs, including medication reduction plans, will be reviewed bi-annually via inter-agency peer review by the QIDP's peer and also annually, by the Quality Assurance department. These reviews will use the recently revised Internal Review packet, which is more specific and inclusive than its previous incarnation. The Program Director is responsible for

ensuring both the peer review and Quality Assurance review processes are completed in a timely and thorough manner. All Internal Review packets, including revisions and corrections, will be submitted to the Program Director for review within ten days of the completion of the review packet by the peer review or Quality Assurance department teams.

5. Persons responsible: QIDP, Program Director, Quality Assurance department
6. Date of completion: April 1, 2017

W436

Please refer to response under W137.

MM134

Please refer to response under W137.

MM159

Please refer to responses under W137 and W260.

MM162

Please refer to responses under W312.

MM169

Please refer to response under W137 and W436.

MM215

1. All broken blinds (6) throughout the home will be replaced.

   All missing floor moldings will be installed.

   Individual #4's end table will be replaced in its entirety.

   Master bathroom's metal garbage can will be replaced.

   Door handles on vanity in master bathroom will be tightened.

   The top ledge of the shower in master bath has been cleaned.

   Door edge and frame on Individual #4 and #5's bedroom will be repainted. All holes in Individual #4 and #5's bathroom and bedroom will be filled. The master bathroom will be re-caulked.

   Individual #1's top dresser drawer will be repaired or replaced. Individual #1's coaxial will be secured to the wall.

   Individual #2's fourth dresser drawer will be repaired or replaced. The hole(s) in the wall in Individual #2's room will be repaired.

   Hall bathroom burned-out lightbulbs were replaced.

   The laundry room door will be repainted.

   Kitchen pantry flooring will be replaced and pantry door handle tightened.

Areas of living room wall requiring paint will be painted.

Flooring in front of dining room door will be replaced.

The patio door threshold and patio door will be replaced.

The backyard south-siding fence will have broken slats replaced.

2. The Program Supervisor will train the Lead Worker to complete the universal checklist more thoroughly. The checklist will be completed by the Lead Worker monthly and submitted to the Program Supervisor for monthly review. The Lead Worker will complete a maintenance request for any identified repair or maintenance needs and will submit it to the Program Supervisor within 24 hours of the identification of the need. The maintenance request goes through a review process including the Program Supervisor, the Program Director, and the Finance Director. The Program Director is responsible for delegating any needed repairs to the agency Maintenance Technician or other applicable outside organizations. The Program Director is responsible for ensuring all repairs occur in a timely manner per agency policy and state regulations.
3. The Program Director will make observations in the home at least once monthly to inspect for repairs needed. Any identified needs will be documented on a maintenance request form within 24 hours of the observation.
4. The Regional Director is responsible for ensuring the Program Director completes these observations and will review these during the monthly one-on-one meeting between the Program Director and Regional Director. These meetings are scheduled by the Regional Director via "Microsoft Outlook." These meetings may occur in person or via telephone or video conferencing.
5. Persons responsible: Program Supervisor, Program Director, Maintenance Technician, Lead Worker, Regional Director
6. Date of completion: April 1, 2017